

MDR Tracking Number: M5-04-2977-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 5/11/04.

The Medical Review Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that the ultrasound, electrical stimulation-unattended, manual therapy technique, joint mobilization, therapeutic procedures, mechanical traction, neuromuscular re-education, mechanical traction, and therapeutic activities rendered on 12/29/03 through 2/24/04 that were denied with "U" from 12/29/03 through 2/24/04 were not medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 7/01/04, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14-days of the requestor's receipt of the Notice. Additional documentation was not submitted.

The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR\$	Reference	Rationale
12/01/03 thru 12/03/03	97010	\$20.00	\$-0-	O, 284		Medical Fee Guideline effective 8/01/03; Ingenix Medicare Part B Correct Coding and Fee Guide	The carrier's EOB dated 3/25/04 denied reimbursement as "O, 284 – No allowance was recommended as this procedure indicates a status 'B'." Medicare establishes certain status designations for the CPT and HCPCS Level II codes to indicate payment coverage within the Medicare Physician Fee Schedule Data Base

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR\$	Reference	Rationale
							(MPFSDB) called procedure code status. Status indicator "B" is defined as "Bundled Code: Service is not paid separately. If service is covered, payment is bundled into payment for related services". Reimbursement is not recommended.
12/01/03 thru 12/03/03	97035-GP	\$32.00	\$-0-	O, 770	\$11.94 x 125%	133.304(c)(1); Medical Fee Guideline effective 8/01/03	The Carrier's EOB of 3/25/04 denied reimbursement as "O, 770 – No allowance has been recommended for this procedure/service/supply. Original EOBs were not submitted for review. The explanation of benefits shall include the correct payment exception codes required by the Commission's instructions, and shall provide sufficient explanation to allow the sender to understand the reasons for the insurance carrier's actions. The Carrier did not provide a valid denial reason for reimbursement of this service; on this basis, reimbursement is recommended in the amount of \$44.76 (\$11.94 x 125% = \$14.92 x 3 DOS).
12/04/03 thru 12/23/03	97035-GP	\$32.00	\$-0-	N-205		133.307(g)(3)(B)	The Carrier's EOB of 3/24/04 denied reimbursement as "N, 205 – This charge was disallowed as additional information/definition is required to clarify service/supply rendered. N – Not documented." The Requestor did not submit relevant medical documentation; therefore, a review cannot be conducted. Reimbursement is not recommended.
12/01/03 thru 12/03/03	G0283-GP	\$28.00	\$-0-	O, 770	\$12.65 x 125%	133.304(c); Medical Fee	The Carrier's EOB of 3/25/04 denied reimbursement as "O, 770

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR\$	Reference	Rationale
						Guideline effective 8/01/03	– No allowance has been recommended for this procedure/service/supply. Original EOBs were not submitted for review. The explanation of benefits shall include the correct payment exception codes required by the Commission's instructions, and shall provide sufficient explanation to allow the sender to understand the reasons for the insurance carrier's actions. The Carrier did not provide a valid denial reason for reimbursement of this service; on this basis, reimbursement is recommended in the amount of \$47.43 ($\$12.65 \times 125\% = \15.81×3 DOS).
12/04/03 thru 12/23/03	G0283-GP	\$28.00	\$-0-	Y, 973	\$12.65 x 125%	Medical Fee Guideline effective 8/01/03; Medicare Fee Schedule; 2003 Ingenix EncoderPro	The Carrier's EOB of 3/24/04 denied reimbursement as "Y, 973 – Payment denied as this modifier is incorrect or no longer valid." "GP" is a valid modifier; therefore, reimbursement in the amount of \$142.29 ($\$12.65 \times 125\% = \15.81×9 (DOS)).
TOTAL							Requestor is entitled to reimbursement in the amount of \$234.48.

ORDER

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees outlined above as follows:

- In accordance with the Medicare program reimbursement methodologies for dates of service after August 1, 2002 per Commission Rule 143.202(c);
- plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this Order.

This Order is applicable to dates of service 12/01/03 through 12/03/03 as outlined above in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Decision and Order is hereby issued this 29th day of October 2004.

Pat DeVries
Medical Dispute Resolution Office
Medical Revision Division
PD/pd

August 20, 2004

Texas Workers' Compensation Commission
Medical Dispute Resolution
Fax: (512) 804-4868

Re: Medical Dispute Resolution
MDR #: M5-04-2977-01
TWCC#:
Injured Employee:
DOI:
SS#:
IRO Certificate No.: 5055

Dear

___ has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, ___ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the Secretary and General Counsel of ___ and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is certified in Chiropractic Medicine and is currently on the TWCC Approved Doctor List.

REVIEWER'S REPORT

Information Provided for Review:

TWCC-60, Table of Disputed Services, EOB's

Information provided by Requestor: letter of medical necessity, office notes and consultations.

Information provided by Respondent: correspondence, exams and H&P.

Clinical History:

The records provided for review indicated the claimant initially reported a work-related injury/injuries to her neck, back, left shoulder, right knee, bilateral feet/ankles, and abdomen during the course and scope of her employment on _____. The worker's injuries did not require emergency medical services and ostensibly, she did not request exigent medical attention.

She was initially evaluated by a D.O. On the basis of this physical examination, (neurologically uncomplicated findings) the treating doctor assessed the worker's condition as: Strains/sprains of the involved motion segments. His diagnostic impressions were later up-curved to include lumbar intervertebral disc disease without evidence of neuropathy. The worker received a protracted course of medical, non-surgical services, formal physical therapy services, and chiropractic manual therapy services. These records indicated treatment as ongoing as of 03/12/04.

Disputed Services:

Ultrasound, electrical stimulation-unattended, manual therapy technique, joint mobilization, therapeutic procedures, mechanical traction, neuromuscular re-education, mechanical traction and therapeutic activities during the period of 12/29/03 through 02/24/04.

Decision:

The reviewer agrees with the determination of the insurance carrier and is of the opinion that the treatment and services in dispute as stated above were not medically necessary in this case.

Rationale:

The treating doctor, the licensed physical therapist, and the treating chiropractor's documentation provided no credible medical evidence of neurological complications/deficit associated with the worker's compensable soft tissue injuries. The records indicated treatment ongoing as of 03/12/04 without indications of an endpoint.

Current peer-reviewed medical literature, evidence-based disability guidelines, the Commission's spine and extremity treatment guidelines, and the chiropractic profession's own consensus document (The Mercy Center Conference Guideline) indicate that soft tissue injuries of this nature resolve typically without complications and without necessity of total temporary disability. In a recent article, in The Journal Of The American Family Physician, Robert Bratton, M.D. notes that 60% of acute back pain cases resolve within 7 days with conservative management. The services in question were not validated as medically necessary services by the documentation submitted by the provider.

Sincerely,